

Maine Revised Statutes
Title 24-A: MAINE INSURANCE CODE
Chapter 56-A: HEALTH PLAN IMPROVEMENT ACT

§4312. INDEPENDENT EXTERNAL REVIEW

An enrollee has the right to an independent external review of a carrier's adverse health care treatment decision made by or on behalf of a carrier offering or renewing a health plan in accordance with the requirements of this section. An enrollee's failure to obtain authorization prior to receiving an otherwise covered service may not preclude an enrollee from exercising the enrollee's rights under this section. [2007, c. 199, Pt. B, §17 (AMD).]

1. Request for external review. An enrollee or the enrollee's authorized representative shall make a written request for external review of an adverse health care treatment decision to the bureau. Except as provided in subsection 2, an enrollee may not make a request for external review under a group plan until the enrollee has exhausted all levels of a carrier's internal grievance procedure and may not make a request for external review under an individual plan until the enrollee has exhausted one level of a carrier's internal grievance procedure. A request for external review must be made within 12 months of the date an enrollee has received a final adverse health care treatment decision under a carrier's internal grievance procedure. An enrollee may not be required to pay any filing fee as a condition of processing a request for external review.

[2011, c. 364, §31 (AMD) .]

2. Expedited request for external review. An enrollee or an enrollee's authorized representative is not required to exhaust a carrier's internal grievance procedure in accordance with subsection 1 before filing a request for external review if:

- A. The carrier has failed to make a decision on an internal grievance within the time period required or has otherwise failed to adhere to all the requirements applicable to the appeal pursuant to state and federal law or the enrollee has applied for expedited external review at the same time as applying for an expedited internal appeal; [2011, c. 364, §32 (AMD).]
- B. The carrier and the enrollee mutually agree to bypass the internal grievance procedure; [1999, c. 742, §19 (NEW).]
- C. The life or health of the enrollee is in serious jeopardy; [2011, c. 364, §32 (AMD).]
- D. The enrollee has died; or [2011, c. 364, §32 (AMD).]
- E. The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services. [2011, c. 364, §32 (NEW).]

[2011, c. 364, §32 (AMD) .]

3. Notice to enrollees. A carrier shall notify an enrollee of the enrollee's right to request an external review in large type and easy-to-read language in a conspicuous location on the written notice of an adverse health care treatment decision. The notice must include:

- A. A description of the external review procedure and the requirements for making a request for external review; [1999, c. 742, §19 (NEW).]
- B. A statement informing an enrollee how to request assistance in filing a request for external review from the carrier; [1999, c. 742, §19 (NEW).]

C. A statement informing an enrollee of the right to attend the external review, submit and obtain supporting material relating to the adverse health care treatment decision under review, ask questions of any representative of the carrier and have outside assistance; and [1999, c. 742, §19 (NEW).]

D. A statement informing an enrollee of the right to seek assistance or file a complaint with the bureau and the toll-free number of the bureau. [1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

4. Independent external review; bureau oversight. The bureau shall oversee the external review process required under this section and shall contract with approved independent review organizations to conduct an external review and render an external review decision. At a minimum, an independent review organization approved by the bureau shall ensure the selection of qualified and impartial reviewers who are clinical peers with respect to the adverse health care treatment decision under review and who have no professional, familial or financial conflict of interest relating to a carrier, enrollee, enrollee's authorized representative or health care provider involved in the external review.

[1999, c. 742, §19 (NEW) .]

5. Independent external review decision; timelines. An external review decision must be made in accordance with the following requirements.

A. In rendering an external review decision, the independent review organization must give consideration to the appropriateness of the requested covered service based on the following:

- (1) All relevant clinical information relating to the enrollee's physical and mental condition, including any competing clinical information;
- (2) Any concerns expressed by the enrollee concerning the enrollee's health status; and
- (3) All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by the carrier or the carrier's utilization review entity. [1999, c. 742, §19 (NEW).]

B. An external review decision must be issued in writing and must be based on the evidence presented by the carrier and the enrollee or the enrollee's authorized representative. An enrollee may submit and obtain evidence relating to the adverse health care treatment decision under review, attend the external review, ask questions of any representative of the carrier present at the external review and use outside assistance during the review process at the enrollee's own expense. [1999, c. 742, §19 (NEW) .]

C. Except as provided in paragraph D, an external review decision must be rendered by an independent review organization within 30 days of receipt of a completed request for external review from the bureau. [1999, c. 742, §19 (NEW).]

D. An external review decision must be made as expeditiously as an enrollee's medical condition requires but in no event more than 72 hours after receipt of a completed request for external review if the time frame for review required under paragraph C would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function. [1999, c. 742, §19 (NEW) .]

E. The carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an external review under this section. [1999, c. 742, §19 (NEW) .]

[1999, c. 742, §19 (NEW) .]

6. Binding nature of decision. An external review decision is binding on the carrier. An enrollee or the enrollee's authorized representative may not file a request for a subsequent external review involving the same adverse health care treatment decision for which the enrollee has already received an external review decision pursuant to this section. An external review decision made under this section is not considered final agency action pursuant to Title 5, chapter 375, subchapter II.

[1999, c. 742, §19 (NEW) .]

7. Funding. A carrier against which a request for external review has been filed shall pay the cost of the independent external review to the bureau.

[1999, c. 742, §19 (NEW) .]

7-A. Confidentiality. Except as provided in this subsection, all records of the bureau or an independent review organization relating to an external review request or external review proceeding are confidential and not a public record under Title 1, chapter 13.

A. A party to an external review may obtain from the independent review organization a transcript or recording of the external review hearing and a copy of any evidence introduced by the opposing party.

[2013, c. 274, §1 (NEW) .]

B. The superintendent shall disseminate to the Legislature and to the public aggregate information related to external reviews conducted by independent review organizations on an annual basis, including:

(1) The number of external review requests by carrier, the number of decisions in favor of the enrollee, the number of decisions upholding the carrier's benefit determination and the number of external review requests resolved prior to the issuance of a decision; and

(2) The categories of external review requests by carrier. The categories may not include personally identifiable information or specific medical condition. The categories must include, but are not limited to, medical necessity, out-of-network referrals, inpatient care, behavioral health, prescription drugs and experimental or investigational treatment. [2013, c. 274, §1 (NEW) .]

[2013, c. 274, §1 (NEW) .]

8. Rules. The bureau may adopt rules necessary to carry out the requirements of this section, including, without limitation, criteria for determining when multiple denials of benefits to the same enrollee for the same or similar reasons are considered the same adverse health care treatment decision. Notwithstanding the requirements of section 4309, rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1999, c. 742, §19 (NEW) .]

9. Rights. This section may not be construed to remove or limit any legal rights or remedies of an enrollee or other person under state or federal law, including the right to file judicial actions to enforce rights.

[1999, c. 742, §19 (NEW) .]

10. Applicability. Decisions relating to the following health care services are subject to review pursuant to other review processes provided by applicable federal or state law and may not be reviewed pursuant to this section:

A. Health care services provided through Medicaid, Medicare, Title XXI of the Social Security Act or services provided under these programs through contracted health care providers; [1999, c. 742, §19 (NEW) .]

B. Health care services provided to inmates by the Department of Corrections; or [1999, c. 742, §19 (NEW) .]

C. Health care services provided pursuant to a health plan not subject to regulation by the State.
[1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

SECTION HISTORY

1999, c. 742, §19 (NEW). 2007, c. 199, Pt. B, §17 (AMD). 2011, c. 364, §§31, 32 (AMD). 2013, c. 274, §1 (AMD).

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